Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1938NTC	A. BUILDING _____ B. WING _____	C 07/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR BEHAVIORAL HEALTH	2516 E LAKE MEAD BLVD N LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a Complaint Investigation conducted at your facility on 7/21/09. The State Licensure survey was conducted in accordance with Chapter 449, Facilities for Treatment with Narcotics; Medication Units, effective April 15, 1998. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00022513 was substantiated.	N 00		
N169 SS=D	449.1548(4) OPERATIONAL REQUIREMENTS In addition to all other requirements set forth in NAC 449.154 to 449.15485, inclusive, each facility for treatment with narcotics and each medication unit shall: 4. Be in full compliance with all applicable provisions of 42 C.F.R. Part 8, all other applicable federal laws and regulations and all other requirements of the SAMHSA and the DEA. This Regulation is not met as evidenced by: Based on record review and interview from 7/13/09 to 7/21/09, the facility failed to notify patients taking Benzodiazepines of a policy change affecting their take-home status.	N169		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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